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## Original Communications.

### CASE OF MONSTROSITY—(SIREN).

By J. B. S. JACKSON, M.D.

THIS form of monstrosity is characterized by a fusion and inversion, or turning backward, of the lower extremities, an absence of any distinct parts, externally, of a foot, a fusion of the lower portion of the pelvis, and a great deficiency of the pelvic organs; the head and upper extremities being well formed.

In the present specimen, which was a typical one, the lower extremities tapered almost to a point from the trunk, and in consequence, perhaps, of the inversion were curved gradually forward. At the extremity was a soft and quite movable appendage,  $\frac{2}{3}$  of an inch in length and  $\frac{1}{4}$  of an inch in diameter. This bore some resemblance to a toe, and on dissection three cartilages were found. The leg was about  $1\frac{1}{2}$  inch in length, and the thigh  $3\frac{1}{2}$  inches; the femur being evidently quite broad at each extremity, and showing that there was a fusion of two extremities. At the hip-joint there was considerable motion, but less at the knee. Two patellæ distinctly felt at the back of the joint. No appearance of anus, nor of genital organs. Over the very lower extremity of the spine was a fleshy and somewhat irregular excrescence, about as large as the top of the finger. The lower part of the thorax, upon the left side, was contracted, and in connection with the internal malformations; and, otherwise, the fœtus was externally well formed. Its weight was 2 lbs. 15½ oz. Length from vertex to tip of extremity, along the back, and following the curve, 16 inches; and from the vertex to the navel, 8½ inches.

On dissection, two days after its birth, the following appearances were found:—

Diaphragm wanting upon the left side, but perfect upon the right. A strong muscular band, however, passed in front of the lower part of the œsophagus and towards the left side. The stomach and

spleen were thus allowed to pass up into the left side of the thorax, and the heart was pushed entirely into the right side.

Right lung sufficiently well; but the left consisted of a single lobe, which was smaller than any one upon the other side.

An upper vena cava entered the heart as usual; but upon the left side the great veins formed a separate trunk that opened into the left auricle. The foramen ovale was irregularly developed; there being one large opening toward which the Eustachian valve directed the blood, and a second and rather smaller opening just below it. This last was in a thin membrane, such as is usually seen below the foramen ovale; and the two openings were separated by a muscular band. The two ventricles communicated, and otherwise the heart was well formed. A second vena cava I have met with several times in monstrosities (see this JOURNAL, March 17, 1864), and once I think it must have existed in an adult who was examined at the Massachusetts General Hospital a few years ago. In this last case, a funnel-shaped cavity led off from the auricle toward the left side and back of the heart; and there, being then much reduced in size, it was accidentally cut off.

The rectum terminated in a cul de sac in or very near to the pelvis, was filled with meconium, and gradually dilated towards the last, so as finally to measure about  $1\frac{1}{2}$  inch in diameter. The large intestine was much contracted, and pretty closely connected by a delicate tissue with the under surface of the liver. Otherwise the alimentary canal was normal; the stomach being in no way remarkable, notwithstanding its unusual situation.

The right lobe of the liver was well, but the left was made up of several small and irregular lobes. The gall-bladder was quite small, but the ducts external to it were properly distributed.

Pancreas externally normal.

The spleen consisted of three distinct masses, each about  $\frac{1}{2}$  an inch to  $\frac{3}{4}$  of an inch in diameter, and two others about the size of a pea.

VOL. III.—No. 3

[WHOLE No. 2138.]

Upon the right side there was a renal capsule, of an oval form, and  $1\frac{1}{2}$  inch in length; but no kidney. This is one of the cases that have been observed several times here, as well as elsewhere, and that show the independence of these organs. Upon the left side the renal capsule was smaller than the other. There was also a kidney that was small for the size of the fetus, and that contained numerous cysts. I have met with cysts several times in malformed subjects, and am inclined to think that, when we find the organs completely transformed into cysts in adults, and generally without symptoms, the disease may sometimes have been congenital. I have examined one case at least that must have been so; but in this one there were symptoms, and they seemed to indicate the fact of the congenital formation. On incision of the organ, in the present case, there was found no appearance of a pelvis. The ureter, which was small above and large below, was impervious, and extended as far as the uterus.

The uterus, which was in two distinct portions, and far apart, appeared very prominently above the serous surface, as two red, fleshy, ovoid bodies, each about  $\frac{1}{2}$  of an inch in length. Each had its Fallopian tube and ovary perfectly well developed; and the left horn, at least, had its round ligament. Below the serous surface, and intimately connected with each horn, was a distinct, whitish, fleshy, somewhat ovoid body, about  $\frac{1}{4}$  of an inch in length, and that, it was thought, might be the vagina. These last were quite impervious; but both horns of the uterus showed a distinct cavity.

The bladder was wanting.

The aorta gave off two extremely small iliac arteries, and was then continued straight along the median line, across the pelvis and up to the umbilicus; two vessels only being seen upon the cut surface of the cord.

The skeleton of the pelvis and lower extremities having been prepared, the following appearances were seen. The ilia were normal. The ischia were intimately fused throughout—the bodies as well as the rami; and, in consequence of the large development of substance, the ilia were not unusually approximated. The outlet of the pelvis was thus closed by a thick mass of what would have been bone, if possible; though between the ischia and the lower part of the spine there was a space of considerable size that was filled with connect-

ive tissue and fat. The pubic bones were depressed and much elongated, and the symphysis was very prominent and largely developed. The obturator foramina were closely approximated, as in Cruveilhier's case (*Anat. Path.*, liv. 40, pl. 6, fig. 6), and only separated above by a strong fibrous band that ran from the fused ischia to the inside of the symphysis pubis, and below by a little connective tissue and fat. The sacrum was very irregularly developed and turned directly backward. The femur was  $3\frac{1}{2}$  inches in length and quite large; convex posteriorly and flattened anteriorly, with pretty well marked edges, and no appearance of a twist, as in one of Cruveilhier's figures. The great trochanter was very broad, and there were two well-developed heads in distinct cavities, and nearly  $\frac{1}{2}$  of an inch apart. Viewed in relation to the iliac and pubic bones, the heads seemed to be in very proper position. Inferiorly there were two large condyles, which must be regarded as internal condyles, but there was no appearance of an intervening one. Upon the back of the knee-joint were two well-developed patellæ, with their ligaments; and these were inserted into the tibia, which was  $1\frac{1}{2}$  inches in length, and tapered down regularly and suddenly to unite with the three cartilages above mentioned. The breadth of the femur across the two heads was  $1\frac{1}{2}$  inch, and across the condyles  $1\frac{1}{2}$  inch.

The muscles about the thigh were most of them very distinctly made out by their origins and insertions, and were well developed:—the psoas magnus, iliacus internus and gluteus maximus; the sartorius, tensor vaginæ femoris, three adductors, rectus, vasti, semi-tendinosus and biceps. The gluteus maximus and medius, gracilis and semi-membranosus were wanting. The adductors were inserted mostly into the line that separated the convex from the flat surface of the femur, and into this last. The recti ran obliquely from the front of the pelvis to the patella. The vasti externi were fused, and formed a very powerful mass of muscle upon the back of the femur. Between the sacrum and ischia a considerable quantity of muscular substance was found; but the fibres seemed mostly to run in a transverse direction, and none of the small muscles that run from the pelvis to the great trochanter were made out. Below the knee no muscular fibres were found.

The excrescence over the lower part of the spine was attached to this last by a loose connective tissue, and a considerable

quantity of muscular fibre that arose from the sacrum; but it seemed to have no connection with the spinal membranes.

The case occurred during the month of December, in the practice of Dr. H. P. Hemenway, of Somerville, who very kindly presented the fetus to the Museum of the Massachusetts Medical College. The mother was 24 years of age, of a nervous temperament, and had previously had one well-formed child and one abortion. In the present case, the child was carried to the full period, though its size would not indicate it. The motions had been very feeble, and were described by her as a fluttering sensation. Quantity of liquor amnii exceedingly small, and the labor was otherwise quite natural. The child gasped for about fifteen or twenty minutes; and, meanwhile, the heart was felt beating strongly upon the right side. The cord was short, small, and had an opaque, diseased look. The placenta was thin, and only three or four inches in diameter; and the vessels were small.

Crucveilhier (*Anat. Path.*, liv. xxxiii.) has given an admirable figure of a specimen of this variety of monstrosity, and of the osteology, and also of the osteology of another case in which the fusion was much less complete. Specimens of the kind are to be seen in European cabinets; but I have not heard of a case here, nor have I happened to see a report of one in our medical journals. Perhaps this remark may lead to the publication of other cases that must have occurred. With regard to the frequency of their occurrence, St. Hilaire states in his general history of the Sirens, as they were formerly called, that only about twelve cases are known (*Anomalies de l'Organization*, vol. ii., p. 250); but I think that he must have underrated the number, as I have seen no less than five in the European cabinets, besides a model of a sixth, and other specimens in which the fusion is less complete than in the Siren.

## TWO CASES IN OPHTHALMIC PRACTICE.

By G. HAY, M.D.

I.—*Suppurative Inflammation of the Cornea, with successful result after Iridectomy.*—The operation of iridectomy is a prominent feature of modern ophthalmic practice. Among its many uses it has been found of advantage in certain cases of disease of the cornea. As an instance of this use of the operation the following case is reported:

Oct. 28th, 1867.—Mrs. X., of small stat-

ure, aged 25, with one child some 5 years old. Has had trouble in the left eye for about two weeks. The vision of this eye is much diminished. The cornea is somewhat opaque in the middle. There has been considerable pain in the region of the eye. The pupil being moderately dilated, a continuance of the collyrium previously used was advised on the supposition that it contained a preparation of atropia. The patient was also advised to take some quinine, to use an opiate lotion and to wear plane blue glasses.

Oct. 31st.—For collyrium of 28th inst., substitute sulphate of atropia gr. ss. to water f3i. The pupil dilates well after instillation of this solution.

Nov. 5th.—Has had considerable pain. There is a very slender, light-colored line along the lower edge of the cornea (in the anterior chamber), an appearance which indicates the coming of pus in the anterior chamber. Advised to take some morphine for the pain.

Nov. 12th.—Pus in anterior chamber quite evident, rising to the height of about a line. Pain less. Pupil dilated. Has applied a large blister to back of neck. Discontinue quinine of Oct. 28th.

R. Ferri et quin. cit. 3i.

Aq. f3iv. M. Dose, f3i.

Nov. 16th.—Pus increased. Eye comparatively easy till to-day. To-day more pain.

Nov. 17th.—Pus movable. With the assistance of Dr. Robert Willard ether was administered. Paracentesis corneæ performed. A small quantity of pus escaped through the puncture.

Nov. 18th.—Had a good night; free from pain. Anterior chamber reestablished. Pupil moderately dilated. Some pus in anterior chamber. Discontinue ferri et quin. cit. Substitute potassii iodid. 3i. to liquid f3iv. Dose f3i.

Nov. 20th.—No pain of consequence. Eye looks better. The pus appears to be less.

Nov. 22d.—Slept well last night, free from pain. Cornea looks as if containing a deposit of pus. Some circum-corneal injection.

Nov. 25th.—Pus in anterior chamber continues; not as much as before paracentesis. The cornea looks as if burrowed. Discontinue potassii iodid.

R. Liq. ferri iodidi gtt. x. ter die.

Nov. 27th.—Light is disagreeable; eye waters when examined; pus increased in anterior chamber; some pain; vision very poor.

Nov. 28th.—With the assistance of Dr.

B. J. Jeffries ether was administered and iridectomy upwards and inwards performed. After the operation the middle of the cornea over an area of from two to three lines in diameter, presented an appearance of honey-combed purulent infiltration, apparently nearer the inner surface.

Nov. 29th.—Comfortable.

Dec. 1st.—Some pain—light disagreeable—eye irritable.

Dec. 3d.—Had a good night. No pain. Eye looks better. No movable pus noticed. Infiltration of cornea apparent.

Dec. 6th.—Sight improving. Pus absorbed. Middle of cornea still infiltrated. The eye very sensitive to light. Use the atropine collyrium only every second day.

Dec. 14th.—No pain. Sees more. Eye still sensitive to light. Discontinue atropine and iron. Resume potass. iodid. R. Borax gr. ss. to water  $\frac{1}{3}$ i. as collyrium. An ointment containing belladonna to the brow. May walk out.

Dec. 21st.—Better. Borax collyrium only once daily. The ointment only every second evening.

Jan. 3d.—Very much better. Continue treatment.

Jan. 22d.—No pain. Redness gone. The opacity almost gone. Vision pretty good. Health good. Treatment discontinued.

Thus in about three months the inflammatory changes had nearly come to an end, the eye being left in a good condition. It cannot perhaps be proved that an equally good result might not have been obtained without the operations. On the other hand, improvement followed upon each operation, though rather slowly for the five days immediately succeeding the iridectomy; and a longer continuance of the disease would very likely have caused permanent opacity of the cornea or serious changes in the iris and lens, or perhaps the morbid processes would even have extended to the deeper parts of the eye. We should therefore consider that the preservation of the eye was due to the interference of art.

II.—*Enucleation of the Eyeball for Intra-ocular Bleeding and Pain following an Iridectomy.*—Mr. J., American, aged 45, farmer, entered the Infirmary July 27th, 1868. Left eye. The sight had been failing for six years, with pain at times. For the past two months the pain has been severe, and for the last five weeks has prevented him from working. No cause was assigned for the disease. Patient formerly suffered much from bleeding from the nose, but less during the last few years.

July 27th.—The eye is of normal size; conjunctiva only slightly injected; cornea and aqueous clear; pupil not remarkable. Lens opaque. Iris tremulous. Tension above normal. Sight gone. It was determined to try iridectomy for the relief of the pain. This was done about noon. Shortly after there was severe pain and the bandage became stained with blood. At 4, P.M., on moving the bandage, the flaccid lens in its capsule was found outside of the eyeball, near the palpebral opening, having been forced through the moderate-sized incision of the iridectomy. In the incision was a small clot of blood. The pain and bleeding continuing, it was determined, after consultation, to enucleate. Enucleation was therefore performed; but as the bleeding—instead of ceasing, as is usual—continued rather freely, the cavity was plugged with sponge, and a tight bandage was applied. On the 29th the sponges were taken out; but owing to a return of the bleeding, the cavity was again plugged. The pressure, however, being disagreeable, was on August 1st diminished.

Aug. 3d.—As the tissues of the lids were much swollen, and smelt badly, and the bleeding still continued, the sponges were taken out. Dr. Hodges was requested to see the patient. In accordance with his advice, a single thickness of cotton cloth wet with iced-water was applied. The bleeding then diminished, but a slight oozing continued.

Aug. 4th.—As a clot of the size of a walnut had formed, which projected from between the swollen lids, and a slight trickling continued, Dr. Hodges searched the cavity, under ether, for bleeding vessels, but found none of sufficient size to tie. The surface of the cavity was sponged clean for about half an hour, and then iced water was applied as before. After this the bleeding stopped, the swelling diminished, and the patient rapidly improved.

Aug. 10th.—Discharged convalescent.

The eyeball, examined the day after the enucleation, was found filled with a clot of blood. After removing the most of the clot the choroid was seen almost entirely separated from the sclerotic and pressed together, passing somewhat like a tunnel from the papilla to the anterior part of the eye.

In consideration of the recent pain suffered we were inclined to think that intra-ocular hæmorrhage had been taking place for some time before the operation; but on the other hand it might be supposed that it was a case of separation of the retina with cataract, and that the hæmorrhage was only



a consequence of the operation in an eye predisposed to it by disease. Although the tension of the eye was above normal, the general aspect was not glaucomatous.

#### EXTRA-LARYNGEAL OPERATION FOR THE REMOVAL OF GROWTHS UPON THE VOCAL CHORDS.

By E. CUTTER, M.D., Boston.

THE patient, Mr. Albert Litch, of Cambridgeport, was born in 1814; he is a large, well-developed, muscular man, of dark complexion and nervous temperament, and has enjoyed excellent health during most of his life. There has been no cancer in the family, except in the case of a paternal aunt who died at the age of 80. His mother is still living, aged 79; his father was a strong man, and died of ague. He was engaged with Mr. John A. Whipple in introducing photography in the United States, and in 1846 he was injured by overturning a large jar of bromine upon his face and hands, the vapor from which strangled him and almost deprived him of life. Since then he has been actively engaged in mercantile pursuits. He attributes his subsequent laryngeal affection to the inveterate smoking of tobacco, which he used to buy by the barrel for his own use. He "supposes that he has colored more pipes than any man in Boston."

In April, 1864, he was attacked with hoarseness, though he is not aware of having taken cold. There was no venereal taint. His case was submitted to various physicians; one of whom gave him some preparation of squill, saying that the disease might or might not pass away; while another, after two months, dismissed him as among the "opprobria medicorum." Another gave him iodine to inhale, which did no good. Subsequently he went to New Jersey, to try the effect of a change of climate, and two physicians there diagnosed a weakness of the vocal chords. He received no benefit; and on his return home he consulted one of our oldest and best known physicians, who told him "to let doctors of medicine alone."

After this for about a year he did nothing but consult almost every physician with whom he chanced to come in contact. He was completely discouraged, and was, he says, disgusted with the whole medical faculty. Naturally he turned to mediums, clairvoyants, astrologers, and other irregular practitioners, none of whom succeeded in curing him or in making a true diagnosis.

Meantime he had sleepless nights; he lost flesh, strength and energy, and became short of breath upon exertion. He became indifferent to life, and was tempted to suicide. He said that he felt "like a man out in the open sea in a boat, without oars or rudder, expecting every moment to be capsized."

In April, 1867, he was brought to the writer's notice by Dr. John Hart, of this city. A laryngoscopic examination revealed a sessile tumor, occupying the whole of the upper surface and free edges of the left vocal band and a small portion of the right vocal band near the thyroid insertion.

The effect upon his mind of a correct diagnosis was wonderful. The hope of relief made him feel better immediately; and he became able to eat and sleep.

After the diagnosis had been confirmed by repeated examinations, at intervals of days, the patient was told that relief was to be afforded only by mechanical removal; that there were two methods of operating, one from the inside and the other from the outside; while the non-pedunculated character of the new growth and its situation upon the upper and free edge of the band and at the thyroid insertion favored the removal by thyrotomy. Before resorting to the latter process, attempts were made to remove a portion by the mouth, with little success. Having been assured that by opening the larynx the work of removal could be effected safely, surely, and thoroughly, the patient then entrusted the whole matter to his adviser.

Sept. 26th, 1867, at 2.30 P.M., the extra-laryngeal operation was performed as follows, in the presence of Drs. Louis Elsberg, of New York City, E. A. Perkins, of Boston, Allen, of Cambridgeport, S. W. Abbott, of Woburn, and Mr. Shurtleff, of Boston. The patient was seated in a common old-fashioned wooden armed chair, with a straight back. His chin was shaved and his person in undress. He soon came under the ether, which rendered him violent and pugilistic. When anesthetized he slipped down in his chair, and at Dr. Abbott's suggestion he was secured by a leather strap buckled round his chair. Pulse 80, full and strong. An incision was made with a scalpel in the median line, from the hyoid bone to the third tracheal ring, through the skin, fat and fascia. The thyrohyoid membrane, the thyroid cartilage, the thyro-cricoid membrane and the cricoid cartilage were denuded. During the dissection there was some embarrassment from the fact that the larynx was in constant motion from con-

tinual efforts to swallow. The denudation measured about two and one half inches in length. The thyroid cartilage was found to be ossified. After the external hæmorrhage had ceased, the lower blade of a bone forceps was entered through the crico-thyroid membrane, exactly in the median line, till it was two-thirds concealed. Simply closing the forceps with force sufficed to sever it cleanly in the middle. The section through the soft tissues was completed with the scissors. The severed parts were held apart by two-tined hooks, one tine above and one tine below the vocal chord. Fortunately the up and down movements here ceased. The new growth was completely revealed. On the left chord it appeared as a minute lobal excrescence, occupying the whole inner edge like a fringe, and the lower or tracheal surface. On the right vocal chord the growth was similar, but close to the thyroid insertion. It proved to be fragile. The whole growth was removed by the scissors, leaving the surface clean and smooth. The surface of denudation was sponged and carefully examined by each gentleman present, in succession, until all were satisfied as to the completeness of the removal. The site was then cauterized with the acid nitrate of mercury.

As soon as the patient passed into the semi-conscious state of recovery he again became violent. The most remarkable feature of the violence was the completeness of his prostration. He spoke in a loud, coarse, resounding voice, resembling that of a sea-captain in a storm. This phonation lasted for several hours. The return to complete sensibility was retarded by the accumulation of blood and mucus in the mouth, which ran down into the trachea and out of the artificial opening; it was also accompanied by profuse sweating and some flagging of the pulse. The wound was closed by five sutures, through the skin only. The patient was then led to his bed in an adjoining chamber. He was faint and chilly, but his pulse was 80, regular and full. Tr. camphoræ and aqua ammoniæ were given, and hot water was placed at his feet. Vomiting then ensued, a large amount of blood mingled with mucus was evacuated, and the patient assumed a more natural appearance.

The night passed without any serious difficulty. The operator slept in the house, but was not called on to do anything. In the morning the report was that he had slept a few hours, but was hot, and his throat was very sore. The pulse was 80, the skin cool, air occasionally passing

through the opening. Voice alternating between a whisper and hoarseness or gruffness. Morsels of ice were freely used in the mouth. The air was kept moist by evaporating water on a stove, and by hot flatirons thrown into firkins containing water. Mutton broth and milk for diet. Tinct. veratri viridis gtt. vj. once every hour, if feverish.

9.30 P.M.—Pulse 72. Skin warm. Throat sore.

28th, 7 A.M.—Pulse 72. Skin chol. Dysphagia. Rather restless through night. No medicine given. Vaporization continued.

29th, 2.15 P.M.—Pulse 64. Wound united.

30th.—Stitches removed.

Oct. 2d.—Patient went down stairs.

5th.—All plasters removed.

8th.—Phonation coarse and clear; pulse 80.

17th.—Under the laryngoscope everything appeared normal except a slight cedematous protuberance towards the thyroid extremity of the left vocal chord.

Oct. 23d.—Throat feels sore, but the larynx looks very well inside, the vocal chords having their normal pearly sheen. There was some adhesion of the cicatrix to the trachea, which was removed by subcutaneous sections.

At the present time there is an appearance of a return of the disease on the right vocal chord.

## Reports of Medical Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.  
CHARLES D. HOMANS, M.D., SECRETARY.

Dec. 14th.—*Typhus Fever without Eruption.* Dr. BORLAND reported the case.

"The patient, a sail-maker, 37 years old, was brought from a house in Salem Street to the City Hospital, on the afternoon of Dec. 4th. He was in a semi-comatose condition, and the only facts that could be obtained were, that he was in the sixth day of his sickness; that there was no sickness in the house from whence he came, and that his room was very small and badly ventilated. When admitted, he was recorded as speechless; not paralyzed; tongue, very dry and brown, could be protruded a little way, in a straight line; skin dry; pulse 132, small, weak; resp. 32.

"Dec. 5th.—I saw him for the first time,

and found him conscious, but speechless; his face had a peculiar expression of a heavy, dull, passive indifference; eyelids and mouth open; the countenance generally flushed with a dusky reddish-brown hue; the tongue was dry and brown, and there was some sordes on the lips and teeth; the conjunctivæ were, however, not injected. The abdomen was somewhat shrunken, not tender. Skin was generally dry throughout. There was no eruption. The urine was passed involuntarily, but enough was collected for examination. It was dark colored; specific gravity 1018; the chlorides wholly absent; there was no albumen. The physical examination of the backs showed harsh respiration, but of feeble character; no râles. Percussion normal. In the afternoon he had two severe clonic convulsions, affecting chiefly the upper half of the body. His pulse varied from 124 in the morning to 132 in the evening. Temperature  $99.5^{\circ}$  to  $103.5^{\circ}$ . Resp. 32. He was ordered beef-tea and brandy, alternately, every hour, and five grains of carbonate of ammonia in camphor mixture every two hours.

6th.—The general condition of the patient was much as described, excepting the lowering of all the vital signs. The pulse ranged from 108 to 124, and irregular in its rate. Temperature from  $98.5^{\circ}$  to  $99.5^{\circ}$ . Respiration 24 to 28. Large ecchymoses were seen on each foot. The tongue could not be protruded. Bowels were costive, and were moved by means of enemata, and he was sponged all over with warm alcohol and water.

7th.—The patient appeared slightly better. His tongue was a little sticky, showing a slight degree of moisture. Pulse 132 in the morning, 120 in the evening; temperature  $100.5^{\circ}$  to  $102^{\circ}$ .

8th.—Pulse 120; temperature  $103^{\circ}$  in the morning,  $102.5$  in the evening. Tongue again perfectly dry and brown; the patient could protrude it half an inch. The respiratory murmur in both backs was good. In the afternoon, he had three loose dejections of greenish-brown feces, and at 10, P.M., he began to show indications of failing vitality, and he died at 12 M. on the 9th of December, it being the eleventh day of his disease.

The fact that was most evident, that the man was suffering from the depressing influences of some severe blood-poison, together with the impossibility of finding anything like organic disease to account for his condition, strongly suggested to my mind the fact of the disease being typhus fever. Yet

the comparative rarity of this disease in the community; the absence of the injection of the conjunctivæ, of the peculiar "rotten straw" smell of typhus and of the eruption kept me in a state of uncertainty as to the true diagnosis, until it was verified by the autopsy.

The argument in favor of typhus was in the following facts:

The physiognomy of the patient, presenting, as he did, the nearly true facies typhosa, the injection of the conjunctivæ alone being absent. The pupils were never dilated, although they did not present the pin-hole pupil which Dr. Graves considered as a fatal symptom.

In the dryness of the skin, as is commonly the case after the third day of the disease.

In the absence of sudamina, and the presence of ecchymoses, as recorded on Dec. 6th.

In the temperature, which in typhus, as a rule, does not exceed 103 to 104, and after the end of the first week is generally gradually lowered, and in extreme prostration even rates lower than the normal standard.

In the correspondence of the respirations with the law of typhus, not being much heightened till the second week, and in the aphonia, our patient either being speechless or only speaking in monosyllabic whispers.

In the peculiar dry brown tongue, and in the absence of meteorism, or gurgling; with the concave abdomen; and the coming on of diarrhoea of dark greenish brown discharges.

In the dark colored urine of the specific quantity of 1018, with absence of the chlorides.

In the general prostration of the patient, with the tendency to dorsal decubitus, in the occurrence of convulsions preceding death, and in the death itself, occurring on the eleventh day of disease.

The autopsy was made twenty-four hours after death.

The cadaveric rigidity was not remarkable, but there was much livid discoloration of the dependent parts of the integuments. The muscles were everywhere of a very unusually dark color.

Head. There was a marked congestion of the cerebral membranes, and also of the choroid plexuses. The larger vessels were filled with blood, but there was no fine injection. The subarachnoid fluid was largely increased—it had a somewhat opalescent look, but it contained no lymph, and ran off clearly and transparently on raising the confining membrane. The substance of the cerebrum and cerebellum was perfectly

healthy, presenting no trace of inflammatory action.

**Thorax.** The blood was in a very fluid condition, looking when in bulk very dark; when dropped out on a white surface, it looked of a thinner quality than usual. In the left ventricle there was a small, soft, friable white clot. The heart was healthy—paler than usual, and without the staining of its lining membranes which is sometimes seen in typhus. The pleuras showed no trace of recent inflammation. Bronchi, healthy. The lungs were healthy, excepting for the condition of hypostatic congestion. The two lungs were about equally affected. The consolidation was greatest at the posterior part; was of a dark purplish color, extending two or three inches into the substance of the lung, was not bounded by defined margin; had a smooth surface when cut, and on pressure exuded a dark non-aërated serum.

**Abdomen.** The intestinal canal was healthy throughout, with this exception. The lower two feet of the ileum were congested, and throughout the lower six feet of the ileum the Peyer's patches partook of the same congestion, so as to be visible to the eye. They, however, were in no ways thickened, stiffened, elevated, or perceptible to the finger, nor was their mucous membrane in any way softened. The bowel at this part contained a considerable amount of greenish fecal matter. Mesenteric glands healthy. The abdominal viscera were generally in a hyperæmic condition, all deeply reddened. The liver was of a normal size. The spleen of double its natural size. The left kidney dark red, much larger than the right, which was of a natural size. There was no other diseased condition detected.

I have considered the autopsy as showing the nature of the disease:—From the absence of inflammation of the brain or its membranes, from the hyperæmia of the cerebral membranes, and increased amount of intra-cranial fluid; from the fluid condition of the blood, the pulmonary hypostasis, and the hyperæmic condition of the abdominal viscera which, had the patient lived a few days longer, would probably have induced softening.

**INTERNATIONAL MEDICAL CONGRESS.**—Professors Palasciano, of Naples, and Pantaleoni, of Rome, have issued proposals for holding an International Medical Congress at Florence in September, 1869. They have laid down the statutes for its management and a programme of the questions to be discussed.—*Med. Times & Gazette.*

## Bibliographical Notices.

*Essentials of the Principles and Practice of Medicine. A Handbook for Students and Practitioners.* By HENRY HARTSHORNE, M.D., Professor of Hygiene in the University of Pennsylvania, &c. &c. Second edition, revised and improved. Philadelphia: Henry C. Lea. 1869. Pp. 452.

THIS work seems to be carefully and conscientiously edited. The hydraulic press, however, applied to reduce a book to one-fourth its proper size, is unfortunately too apt to squeeze it dry of flavor, excepting the flavor characteristic of dictionaries. To read such compendia continuously, is to violate the laws of mental hygiene, while a close examination is apt to show that important facts are dropped, and important subjects neglected. For instance, in treating of pneumonia, the author omits to describe the "jacket poultice." In rheumatism, he represents Dr. Davies as using small blisters, intended to produce moderate vesication only, applied to the different joints in succession—instead of large blisters *simultaneously* applied. In treating croup, he seems to be unaware of the paramount value of a steam-atmosphere, before tracheotomy is performed—although he speaks of the efficacy of the vapor of lime-water as a solvent of croup-membrane. He has abandoned tracheotomy in his own practice. The newer additions are valuable and useful.

D. F. L.

## Medical and Surgical Journal.

BOSTON: THURSDAY, FEBRUARY 18, 1869.

### OVARIOTOMY—NOTE FROM MR. T. SPENCER WELLS.

WE had set aside the following extract from the *London Medical Times and Gazette* until such time as we should receive from Mr. T. Spencer Wells a reply to a note addressed to him by us. We wrote to that gentleman asking to be informed who was entitled to the honor of having invented the clamp used in his operations. Through the kindness of Mr. Wells, his reply has come promptly to hand; and we now give it, immediately succeeding the extract referred to.

In an article in the *London Medical Times and Gazette*, Mr. Wells, speaking October 28th, 1868, says:—

"Since October last I have completed the operation of ovariectomy in this hospital in thirty-six cases; besides one case in which I performed the operation successfully for the second time on the same patient. Of the thirty-six women, thirty-one recovered and five died; and it is a remarkable fact that in *every* case in which the pedicle was long enough for me to use the clamp the patient recovered. There were thirty of these cases—thirty clamp cases in one year without a single death."

{ 3 UPPER GROSVENOR STREET,  
London, 25 January, 1869.

DEAR SIR,—The credit of the introduction of the use of the clamp in ovariectomy is certainly due to Mr. Hutchinson, Surgeon to the London Hospital. He first used one in 1858. It was simply the common *calliper* of carpenters which he used and left applied, handles and all. Then the handles were made movable, so that they could be taken off as soon as the clamp was fixed. Then I made the blades parallel, and did without handles. But I afterwards returned towards the original form of clamp, altering the joint and the form of the opposing surfaces of the clamp until I arrived at that which I now use. You may see it figured in *Druitt's Vade Mecum*, ninth edition, 1865, page 541. . . . I have now completed 300 cases. Of the

1st 100 cases	64 recovered	and 34 died.
2d 100 " 72	" " 28 "	
3d 100 " 77	" " 23 "	
300	213	85

A general mortality of 28 per cent., but it is very encouraging to note that the mortality has been steadily diminishing with increasing experience.

Yours very truly,

T. SPENCER WELLS.

The *New York Medical Journal* for January has an article "On the Microscope as an Aid in the Diagnosis and Treatment of Sterility," by J. Marion Sims, M.D., New York. The paper was read at the meeting of the Medical Society of the County of New York, Dec. 7, 1868.

Previously to the discussion of the topic contained in the above caption, Dr. Sims touched upon the question of the incision of the cervix uteri. So far as such incision

VOL. III.—No. 3a

for dysmenorrhœa is concerned, he has "nothing to recant, nothing to undo." But, when it is proposed to do this operation for sterility, without regard to the relief of physical suffering, he has a word of advice for his younger brethren. He looks upon this procedure as "one of great importance, as one of the most valuable in uterine surgery," but thinks we have too blindly followed "the example and teachings of its illustrious author, Sir James Y. Simpson." Speaking for himself, he says: "I am now sure that I have cut open the cervix uteri, perhaps scores of times, when it was both useless and unnecessary; and I know that others have done the same thing." He is confident that almost every surgeon who has performed this operation often has fallen into the same error. He begs, however, not to be misunderstood. It is for sterility that he declares the slitting of the uterine neck to be useless under certain circumstances—as where the husband is sterile. For this frank and manly avowal, we desire to accord to Dr. Sims all credit and honor.

Coming to the main question in his paper—the investigation of the cause of sterility in particular cases—he takes these positions:—1. We must be sure that we have semen with spermatozoa; 2. We must ascertain if the spermatozoa enter the utero-cervical canal; 3. We must determine whether the secretions of the canal are favorable or not to the vitality of the spermatozoa.

Dr. S. claims that with the aid of the microscope, all these questions may be easily settled. He says:—

"When I wish to examine the action of the cervical mucus upon the spermatozoa, I order sexual intercourse in the morning—the dorsal decubitus to be retained for an hour afterward; and I expect a visit from my patient four, or five, or six hours after coition. Sometimes we find spermatozoa in great abundance in the cervical canal, and not one living. (I have occasionally examined the mucus six, eight and ten minutes after coition and found all the spermatozoa dead.) Sometimes we find half of them dead; again, only about a third; again, two thirds."

"Thus, then, by microscopical examination of the secretions of the vagina and cer-



vix, he ascertains whether the spermatozoa reach the cervical canal, and whether they are able to live there. If no zoöspersms are found, he still knows that the spermatic fluid has entered the vagina and been retained there if he discovers in that cavity "a fluid with the characteristic seminal odor." He has never, but in two instances, "been compelled to resort to Mr. Curling's plan, of getting the man to squeeze a drop of mucus from the urethra, upon a bit of glass, immediately after sexual intercourse." Dr. S. knows many men whose seminal fluid is devoid of spermatozoa, and who therefore cannot become fathers.

"They are all strong, active men, in the prime of life, and all perform the sexual function with vigor. The very fact of their natural vigor and strong passions had been their ruin, for most of them had contracted urethritis during their early and unmarried life, and had suffered from its unlucky sequence, epididymitis. To further illustrate the necessity of the microscope in this department of surgery, I shall append a few cases drawn up as succinctly as possible."

As we once expressed an aversion to some of Dr. Sims's experiments, we think it only just to quote his defence of them, in reply to the animadversions of an English Editor. He says:—

"Now, for myself, I see no indelicacy or impropriety in taking mucus from the vagina and uterus for microscopic examination. It is no more indelicate, no more impure, than to investigate the character and properties of saliva, or bile, or urine, or feces, or pus. And where is the scientific physician, nowadays, who could or would dare to give an opinion on any obscure and complicated disease without some such investigation? To answer that question, I have only to call to the witness—and such men as Beale, Hughes Bennett, Gull, George Harley, Sir William Jenner, Bence Jones, George Johnson, Stokes, and the immortal names of Addison and Bright; and in my own country, the great names of Alonzo Clark, Austin Flint, John T. Metcalfe, and a host of others. Opposition and ridicule are ever ready, but never yet crushed out a great truth. With the simplicity of my nature, and with the honesty of my purpose, there can be no indecency, and no sacrifice of self-respect in making any necessary physical examination whatever, if it be done with a proper sense of delicacy, and with a dig-

nified, earnest, and conscientious determination to arrive at the truth—a truth without which every step is in the dark, but with which all is as clear as the noonday's sun."

We must say, however, that we have not yet conquered our prejudices in this matter. Nevertheless, we fully recognize the enterprise, tact, and originality which have enabled Dr. Sims to rescue many a patient from a living death, and which have won for him an immense reputation.

*Unilateral Sweating of the Head* is discussed in the *Quarterly Journal of Psychological Medicine* for January, by Roberts Bartholow, M.D. of Cincinnati. The same subject has also been recently brought forward in one of the English journals.

We quote one of Dr. B.'s cases as illustrative of the affection.

"A lady of this city, aged about 40 years, of full habit, inclining to *embonpoint*, consulted me for a peculiar redness of the right side of the face and head, coming on at irregular intervals. She first observes a sensation of warmth in the part; her eye suffuses, and vision becomes dim. Making observation with a thermometer, placed in the right meatus auditorius, at my request, she ascertained that there was an actual rise of 5° F. over the temperature of the opposite side. The redness of the affected skin was quite apparent to those about her. Observing her in one of these attacks I perceived an abundant moisture break out all over the reddened surface, while the corresponding parts on the opposite side were perfectly dry. There did not appear to be any other departure from the healthy state."

Dr. Bartholow says:—

"The cases of unilateral sweating which I have thus observed, and those which I have collected from various sources, may be arranged in four classes:

"Those connected with aneurismal or other tumors in the thorax;

"Those occurring in certain neuroses, as epilepsy, progressive locomotor ataxia, &c.;

"Those connected with a peculiar stomach disorder;

"Those which seem to be independent of any alteration in the function of any organ except the affected skin.

"With regard to the cases belonging to the first class, there can now be no doubt of the correctness—in part at least—of the view entertained by Dr. Gairdner. He at-

tributes the sweating to pressure of the new formation upon the cervical sympathetic or its branches; paralysis of the vaso-motor nerves is thus induced, and an increased supply of blood is thrown into the capillaries of the sudoriparous glands. This explanation is predicated upon the remarkable experiments of Claude Bernard, who demonstrated that division of the cervical sympathetic was followed by unilateral congestion of the vessels on the same side. It is probable, however, that the result in cases of unilateral sweating of the head, connected with tumors in the chest, is not always due to *paralysis* of the fibres of the cervical sympathetic, but to irritation by pressure."

"Mr. Hutchinson has very clearly expressed his views as follows:

"Many clinical facts seem to me to concur in pointing to the sensory nerves as those of most importance in reference to trophic disturbance. At any rate, if it be not the sensory nerve-fibres themselves, it must be some others which travel in close company with them, which are the most important ones. Paralysis of the cervical vaso-motor nerve, although followed by increased supply of blood, is not productive of inflammation. Nor have we any facts in support of the idea that injuries to motor nerves cause inflammation. On the other hand, we find in reference to sensory nerves, the following facts: 1. The crop of vesicles characteristic of herpes zoster is usually mapped out most accurately by the area of distribution of some sensory nerve. 2. That when a sensory nerve, such as the first division of the fifth, is paralyzed, inflammation often follows (of the eye in the case of the fifth). 3. That when certain sensory nerves are irritated (not paralyzed), reflex inflammations often ensue. 4. That after section of mixed nerves, or of the spinal cord, the parts left without sensation often inflame."

"The facts of Dr. Prevost, however, show that irritation of a ganglion of the sympathetic is followed by elevation of temperature and increased secretion of the part to which its filaments are distributed. These experimental facts are quite in harmony with our clinical observations in, unilateral sweating of the head. This disorder seems therefore to be produced by an irritation of a ganglion of the sympathetic, and probably has no relation to those trophic disturbances caused by injury of a sensory nerve. I think it is evident, then, that in the fourth class of cases, although no lesion

is discoverable, some disorder exists in one or more of the ganglia of the sympathetic."

The discussion of the merits of *Veratrum Viride* as a therapeutic agent, which has seemed to be somewhat hibernating in this vicinity for some time, has taken its place on the *tapis* abroad. Its power as an arterial sedative is well established; but it is also claimed to be beneficial in pneumonia. Does it always promote the well-being of the patient in that disease? Pneumonia, as we see it now-a-days, if unilateral, usually gets well of itself, when of course the pulse subsides to its usual rate. Does not the accelerated rate of the circulation supply a demand of the system for the aëration of the blood during the period that inflammation shuts off from activity a portion of the respiratory apparatus?

We insert here an account of a case of *Aphasia*\* which occurred in the practice of Dr. Parker, of Melrose. The case was reported at the last meeting of the Suffolk District Medical Society by the Secretary, Dr. John Homans; and obtained from him by the interposition of the assistant editor:

The patient, a clergyman, was about 52 years old at the time of his death. In March, 1867, he had motor paralysis, lasting half an hour, of the left hand and the left side of the mouth and tongue. Occasional numbness of the left hand and the left side of the tongue, during the next few months. He preached through the summer of 1867, but felt miserably. On the 31st of December, 1867, he preached for the last time. He was then unable to recollect quotations; yawned a good deal.

Jan 1st, 1868.—Was suddenly attacked with unconsciousness, which lasted twelve hours; when he recovered, he dragged the right foot in walking. During the next four months he mis-named things. He called a watch "golden vase;" toothpicks, "pick-pockets," &c., but laughed at his own errors, and repeated the right names when told. In June he had another apoplectic seizure; he fell suddenly, but recovered in a few days. During the next six months he improved in general health, and gained flesh and strength.

Jan. 22d, 1869.—Felt uncomfortable; feeling increased until the 24th. On the forenoon of that day his speech became

\* Vide case of *meningo-cerebritis*, page 11, issue of 4th inst.

thick; at 11, A.M. he became unconscious, with stertorous breathing; convulsions set in, chiefly of the right side, and he died, on the 25th, at 4½, P.M.

Autopsy, Jan. 27th, by J. Homans, M.D. The right hemisphere filled the dura mater more completely than the left. The dura mater covering the left frontal convolutions appeared somewhat shrunken, as if the portion of the brain under it were lessened in size. The walls of the arteries of the brain, where not atheromatous, were very thin. The extra-ventricular lobe of the corpus striatum on the left side was divided by the remains of a former apoplectic clot. This spot had a puckered, cicatrized look, was almost linear in shape, and was surrounded by a distinct membrane of a golden-yellow or brownish color. Its cavity was tubular, scarcely half a line in diameter, and irregular in shape; it extended forwards into the cerebral substance half an inch beyond the corpus striatum. Almost no fluid was found in the second ventricle. The septum lucidum was very soft; the right posterior portion of the corpus callosum and of the roof of the right ventricle was quite soft. In the right hemisphere there was a recent clot, purple in color, rather irregular in shape, and about as large as an almond, situated below and behind the corpus striatum, and involving a portion of its cortical substance about one line in thickness. Neither the third frontal convolution of the left anterior lobe, nor the island of Reil, nor the anterior convolution of the middle lobe were diseased. The two effusions occurred in nearly symmetric localities; both were in the extra-ventricular portions of the corpora striata, and both invaded the white substance—on the left side about half an inch anteriorly, on the right about an inch below and behind. The old apoplectic effusion, in the left hemisphere, was *probably* the more extensive. Many red granules, and some blood-crystals, were found in the membrane lining the cavity of the old clot. The arteries seemed to have no aneurismal dilations. The heart was hypertrophied (weight one pound), and was free from valvular disease. The kidneys were granular; the tubuli were crowded with granules. The peculiar affection of speech was only noticed after the attack of January, 1868. It should be added that no symptoms of renal disease were observed during the life of this patient, nor was the urine ever analyzed. The heart's action had been tumultuous, but not irregular.

We make the following extracts from different numbers of the *Union Médicale*:—

In a paper on certain internal symptoms connected with *Locomotor Ataxia*, Dr. Fénelon gives an illustrative case, promising to report two more similar ones. He lays down as belonging to, and characteristic of the disease, disorders of sensation and of muscular action in the larynx, in the bronchi, in the diaphragm, and in the whole apparatus of the respiratory function.

*Dr. Brown-Séquard on the Seat of Epilepsy.*—At the Académie Impériale de Médecine, Jan. 5th, 1869, Dr. Brown-Séquard communicated the results of some new researches he had made in relation to the effects of lesions of the spinal marrow. He reminded the Academy that twenty years ago he had produced in guinea-pigs epileptic or epileptiform symptoms by cutting through one of the lateral portions of the spinal marrow in the vicinity of the tenth dorsal vertebra. Three weeks or a month subsequently, the animals which had undergone this operation were seized with veritable epileptic "crises." To bring on these attacks, it was sufficient to irritate the skin of the face or neck. Later, the spasms manifested themselves spontaneously, and occurred several times a day.

Dr. Brown-Séquard has recently repeated his experiments with variations. He has ascertained that epilepsy can be artificially produced not only by the section of either half of the spinal marrow in the vicinity of the tenth dorsal vertebra, but also at points higher up, and nearer to the medulla oblongata. He has seen the attacks come on after double section, likewise; and, also, the production of convulsions in the muscles which are supplied with nerves proceeding from the segment of the spinal cord included between the two sections. The new experiments demonstrate, their author claims, that the greater part of the spinal cord has an active share in the production of epileptic convulsions.

At the session of the 12th of January, Dr. Brown-Séquard said that he had collected together, in a book published in 1857, twelve or thirteen cases of diseases or traumatic lesions of the spinal marrow, which diseases or lesions had produced epileptic symptoms. But, he does not infer from

those facts that the spinal marrow was the seat of the epilepsy. He merely believes that the cord, under the influence of certain lesions, becomes the seat of a special modification, in virtue of which there are produced elsewhere organic troubles from which result the epileptic phenomena.

The Professor, in presence of the Academy, experimented on four Guinea-pigs which he had subjected to section of the spinal marrow about two months previously. One of these animals, which had had its spinal cord cut on both sides, went through attacks of convulsions when the two (*les deux*) sides of the face or neck were pinched. Those which had undergone unilateral section merely, had the symptoms only when the skin of the side operated on was irritated. Dr. Brown-Séquard showed besides a female Guinea-pig which had been impregnated a short time after section of the cord. The mamma of the paralyzed side secreted milk more abundantly than that of the well side.

At both sessions of the Academy, when our *savant* set forth his researches upon epilepsy, there was some discussion, on the part of different members, as to whether the convulsions artificially produced in the Guinea-pigs were really epileptic. Relative to the fact observed by Dr. Brown-Séquard of the turgescence of the mamma on the paralyzed side in a female Guinea-pig, M. Gubler stated that he had noticed and reported analogous phenomena as occurring in conjunction with paralysis in the human subject—i.e., hyperæmia of the lachrymal and salivary glands accompanying facial paralysis.

Dr. Brown-Séquard remarked that he had once had a good deal of doubt about the epileptic nature of the symptoms which he had brought out in animals; but after long comparative study, he had arrived at the conviction of the identity of the disease in man with the symptoms produced in his experiments. In reply to objections founded on certain distinctions which Dr. Chauffard had attempted to set up between the two classes of lesions, he declared that "loss of consciousness" was produced in the animals artificially made epileptic; and as to the question of epileptic *anæsthesia*, he

could pinch the creatures, prick them, burn them during the *attaque*, without determining other phenomena than movements due to reflex action. These latter phenomena have been perfectly well established as occurring in the human epileptic. There exist in epilepsy artificially induced, the three principal characteristics of epilepsy in man—viz., loss of consciousness; convulsive action; and intellectual torpor following the attack.

The attention of the Academy has also been engaged by reports of committees and discussions upon the noxious effects alleged to proceed from the use of *cast-iron stoves*. We are all familiar with the instructions given by Dr. George Derby, of this city, as to the property possessed by carbonic oxide gas (which is so poisonous), of escaping through cast iron, when that metal is just upon the point of becoming red-hot. The asserted production of typhoid fever by this gas escaping from cast-iron stoves was denied by M. Vernois on the basis of statistics. It was also declared by M. Coulier that a rigid analysis showed the dose of carbonic oxide furnished by a cast-iron stove to be really infinitesimal; and, as usually diluted in the air of a room, to be incapable of toxic effects. In the experiments of MM. Henri Deville and Troost it was proved that each *litre* of air contained only sixteen hundredths of a cubic *millimètre* of this gas.

It was said, on the other hand, however, that the calculations of M. Coulier did not settle radically the question of the noxious influence of cast-iron stoves, though they contributed to its solution. And M. Cloquet thought there could be no doubt that that form of heating apparatus was the source of injurious influences.

We append three questions. How large a proportion of carbonic oxide to atmospheric air is necessary to poison to death, at one session (or one *decubitus*) of a certain number of hours? How small a dose of the gas is infinitesimal—i.e., incapable—when daily respired, for many days in succession—of causing malaise, lowered vitality, or impaired health? Will sheet iron transmit the carbonic oxide on the same terms and conditions as cast iron?

Further reports on this important question are forthcoming. Meanwhile we may remark that M. Carret, who is prominent upon that side of the investigation in France, which is maintained with equal prominence by Dr. Derby here, believes he has discovered a new disease originating in the mode of heating above discussed.

Before leaving this subject, we would refer to the remarks—founded on clinical observation—of Dr. Alden, in *JOURNAL* of 6th inst., page 7.

**PERSONAL.**—A former Editor of this *JOURNAL* has the heartfelt sympathies of the profession in his recent bereavement.

The family physician as well as the teacher should read and ponder "An Address delivered before the Massachusetts Teachers' Association, October 17th, 1868," by Dr. H. W. Williams, on Optical Defects in School Children. We had marked extracts which are crowded out.

We have received from Messrs. Leach & Greene one of their "improved steam atomizers." The apparatus is well made, and does its work to our entire satisfaction.

**ICTERUS AND PNEUMONIA.**—Oppolzer, in a clinical lecture, says that in Berlin the coincidence of icterus with pneumonia has been considered to constitute a distinct variety of pneumonia. In his opinion, however, "the whole difference between bilious and non-bilious pneumonia is, that in the former case a certain complication is present. We meet now and then, especially in summer, cases of pneumonia accompanied with severe icterus, a disposition to diarrhoea, delirium and apathy; the abdomen swells, the tongue dries quickly, and the disease assumes a typhoid character. Such cases often occur in large numbers, and it is usual to say that they ought not to be treated by bleeding. But who says that it is an established custom to bleed in pneumonia? Only in Italy, at the present day, is the maxim of ancient physicians still reiterated—'Pneumonia—blood-letting.' We bleed only when the congestion is so great as to threaten, in the lungs, suffocation; in the brain, sopor or paralysis; or when the disease runs a very rapid course, and a large quantity of bloody sputa is thrown up.

We bleed, therefore, not because of the pneumonia, but in spite of it."

He denies that icterus can be caused by suppression of the secretion of bile, or by sanguineous congestion of the liver. He describes two kinds of icterus. In one (hepatogenous), the secreted bile is reabsorbed; this fact is indicated by the brown color of the urine. The other (hæmatogenous), he ascribes to the dissolution of the blood-corpuscles, and the transformation of their hæmatin into hæmatoidin; a substance which Brücke states to be identical with bilifulvin. In this case biliary acids are not found in the urine.

In the majority of cases, when icterus occurs during pneumonia, it is associated with gastro-duodenal catarrh, white stools, and brown urine. If severe, it is a dangerous complication; and the danger increases in proportion to the diminution of the urine, and the accumulation of biliary acids in the blood. Paralysis of the central and of the circulatory nervous systems is the consequence of this state of the blood. Edema of the lungs comes next in the logical order of phenomena; it is usually preceded by symptoms of prostration, apathy, and delirium; râles are heard in the chest, and death follows with symptoms of edema and paralysis of the heart. This is the mode of death in all diseases of the liver.—*Allg. Wiener Med. Zig.*, Jan. 12. D. F. L.

From an able and interesting article in the *New York Medical Journal* on the Mechanism of the Crepitant and Subcrepitant Râle, by Austin Flint, M.D., Professor, &c., we make the following extracts:—

"For my knowledge of the artificial production of the crepitant râle in the way I am about to describe, I am indebted to my friend and associate, Dr. Henry F. Walker. Dr. Walker happened to purchase an article labelled 'Patent India-rubber Sponge,' which is designed to take the place of the ordinary sponge for the toilet. The article consists of a block of India-rubber which has been made to assume a cellular arrangement, evidently by the introduction of air or gas while the substance is in a liquid state and during its congelation. On examining the article, it will be seen to be made up of cells of unequal size, the appearance being very like that of a portion of emphysematous lung. The elasticity of the India-rubber causes the article to expand after it has been compressed, the well-known cohesiveness of this substance offer-



ing a certain amount of resistance to the expansion. Now, after having examined the structure, if each one present will compress with the fingers the article which I shall presently ask you to pass around, holding it close to the ear, and then allow it to expand, it will be at once perceived that a crepitant râle is beautifully represented. The fineness and dryness of this râle are perfectly exemplified. It will be observed that the compression of the article causes no sound. This act of compression is to be considered as taking the place of expiration. The expansion is analogous to the movement of the lung in inspiration. The compression brings the walls of the cells into contact, and, from the adhesiveness of the substance, they cohere with a certain amount of force. There being no liquid present, the râle must be produced by the separation of the cell-walls by the elasticity of the substance.

"The production of the crepitant râle, in the manner now illustrated, demonstrates the error of attributing the fineness of the râle to the small size of the cells. The fineness is not less marked when produced by the India-rubber sponge than when it emanates from the pulmonary vesicles and bronchioles. Dr. Carr's mode of illustration, by pressing together and separating the finger and thumb moistened with thick paste or mucilage, also demonstrates this error. . . . The application of the 'India-rubber sponge' to show the mechanism of the subcrepitant râle was suggested by Dr. William J. Chandler, one of the house-physicians at Bellevue Hospital. If a portion of the 'sponge' be compressed and allowed to expand under water, the cells are filled with liquid; and now, holding it close to the ear and alternately pressing it and relaxing the pressure, fine bubbling sounds are produced. That bubbling is caused by the pressure, is shown when the portion of 'sponge,' of the cells filled with liquid, is compressed under water; small bubbles, of unequal size, in great abundance, rise to the surface. This artificial subcrepitant râle is produced alike by the pressure of the 'sponge' and by the expansion after the pressure; thus, the fact of the occurrence of this râle, as a morbid sign, in both inspiration and expiration, is illustrated.

"The bubbling, as thus produced, is very fine, and the resemblance of the subcrepitant to the crepitant râle is admirably shown by producing alternately, with two portions of 'sponge,' one portion dry and the other filled with liquid, the representa-

tions of the two râles. This may be practised with advantage in order to exercise the ear in discriminating the differential characters of these two râles.

"The crepitant râle" being "caused by the separation of the walls of the air-vesicles and bronchioles, in the manner explained by the late Dr. Edson Carr, of Canandaigua, N. Y., in 1842, it is highly probable that the peculiar quality pertaining to the inspiratory sound in the healthy murmur of respiration is due to the same cause, the cohesion of the walls of the air-vesicles and bronchioles not being sufficient to give rise to a crepitant râle."

This suggestion is claimed as original by Dr. Flint.

#### PNEUMONIA, BLEEDING, RAPID RECOVERY.

Under the care of Dr. WILKS.—We are indebted to the *Buffalo Medical and Surgical Journal* for the following extracts from a passage it quotes from *Guy's Hosp. Rep.*

"L. B., aged 18, a servant girl, small but robust, was admitted Sept. 23d, with rational symptoms and physical signs of pneumonia. She got a saline and some Dover's powder. . . . On the following day she was worse, and towards evening was excessively ill; the fever was very high, and there was great oppression of breathing; crepitation was heard all over the remainder of the right lung, and there was some suspicion of the left lung having also been attacked. Mr. Reginald Stocker having informed Dr. Wilks of her condition, the latter ordered her to be bled, and to have calomel, antimony, and opium pill every four hours. This was accordingly done, and with very marked and quick relief to her oppressed breathing. On the following day she was much more comfortable; bronchophony now heard at top of lung; the left quite free. On Sept. 26th the febrile symptoms were subsiding; physical signs of consolidation of lung pretty perfect. On the 28th, much better; fever departing; sputa bronchial; to omit the pills. In a day or two she left her bed, rapidly convalesced, and left the hospital quite well on October 14th.

"As regards bloodletting, Dr. Wilks said he had no data on which he could found an opinion as to its value in pneumonia or other diseases, as an antiphlogistic—that is, as to its power in arresting the inflammatory processes; but he had no doubt as to its good effects in relieving congestion of the lungs under any circumstances. He believed therefore, firmly, that he had seen

venesection save life in pneumonia, bronchitis, heart disease, apoplexy or epilepsy. In pre-auscultatory times it might be that the doctor was apt to style many chest affections pneumonia; but when he was called to a patient sitting up in a chair, livid in the face, panting for breath, and he took out his lancet, and whilst he was bleeding *pleno rivo* he saw tranquillity restored, he could not be mistaken as to the good effects of his remedy. Thus it was in the case above reported; immediate relief was obtained, and it may be, as Mr. Stocker thought, an arrest to the further progress of the inflammation."

We are indebted to H. Sidney Everett, Esq., for a copy of the "First Annual Report of the St. Joseph's Home for Sick and Destitute Servant Girls, No. 45 East Brookline Street, for the year ending Jan. 1, 1869. The President is H. Sidney Everett, Esq.; Vice President, Very Rev. F. F. Lyndon; Treasurer, J. F. Tallon, Esq.; Secretary, John Conlon, Esq. The medical staff is thus composed:—Wm. Read, M.D., Charles G. Putnam, M.D., Consulting. Physicians—Wm. Ingalls, M.D., Hall Curtis, M.D., D. F. Lincoln, M.D., W. F. Munroe, M.D. Surgeons—F. H. Brown, M.D., John Homans, M.D., F. B. Greenough, M.D., S. W. Langmaid, M.D. It is stated that—

"The greater part of our inmates . . . and the class we especially intend to assist, consist of those hard-working servant girls out of place, who have become exhausted and unwell while at their work, and need a temporary respite on such terms that, though far from home and friends, they can find a good home by a moderate payment, or a little light work as equivalent, having a chance during convalescence to seek a new situation, if they do not return to their old one."

**ETHER.**—Among the *Ephémérides Médicales* it is recorded that the lamented Malgaigne announced to the Academy on the 12th of January, 1847, that having been put in possession of the "American facts" relative to the employment of sulphur ether for the purpose of blunting sensation, he had tried this agent five times at the *Hôpital Saint-Louis*. A young man of 18 years, with a suppurating phlegmon of the leg, was subjected to the inhalation. At the expiration of ten minutes there was "cataleptic coma." The surgeon made an extensive incision. Two minutes afterwards, the patient awoke. "I am going to operate on you," said Malgaigne. "I am quite willing, since it is necessary," replied the young man. He had felt nothing.

An extirpation of a cervical gland, another operation very similar to that, and an amputation of a leg followed—with entire freedom from pain. One only of the five patients was not rendered insensible by the inhalation.

**DR. W. T. THOMAS**, in the *Transactions of the New York Medical Society*, suggests how *smallpox* and *scarlet fever* may spread, in these words:—

"But the poisons of smallpox and scarlet fever will spread in spite of free ventilation, and they retain their power of causing the same disease for

a long time, and, in the case of scarlet fever, for months. Then the scabs and epidermic scales are doubtless the active agents of propagation. In the one case, the poison may be a mere cloud of molecules; in the other it may be contained in the epithelium and pus-cells, thrown off from the skin in both cases, and from the throat also in one, which adhere to the walls, clothing, or carpets, becoming partially dry; but then, being dislodged by sweeping, dusting, &c., are blown up into the air and inhaled into the lungs of some one, where they again become active by means of warmth and moisture."

**CASE OF CO-EXISTENT TENIA SOLIUM AND TENIA LATA.**—F. Hinkle, M.D., of Columbia, Pa. (*The Humboldt Medical Archives*), reports a case of co-existent *tenia solium* and *tenia lata*, which was relieved by an aqueous extract of the bark of the pomegranate root.

### MEDICAL DIARY OF THE WEEK.

**MONDAY, 9 A.M.**, Massachusetts General Hospital, Med. Clinic. 9 A.M., City Hospital, Ophthalmic Clinic. **TUESDAY, 9 A.M.**, City Hospital, Medical Clinic; 10 A.M., Surgical Lecture. 9 to 11 A.M., Boston Dispensary. 10-11 A.M., Massachusetts Eye and Ear Infirmary.

**WEDNESDAY, 10 A.M.**, Massachusetts General Hospital, Surgical Visit. 11 A.M., OPERATIONS.

**FRIDAY, 9 A.M.**, City Hospital, Ophthalmic Clinic; 10 A.M., Surgical Visit; 11 A.M., OPERATIONS. 9 to 11 A.M., Boston Dispensary.

**SATURDAY, 10 A.M.**, Massachusetts General Hospital Surgical Visit; 11 A.M., OPERATIONS.

**TO CORRESPONDENTS.**—The following communications have been received:—Report from the Eye and Ear Infirmary—Report from the City Hospital—Letter from Vienna—Translation from the German—Cerebral Anaurosis—Cases of Herpes Zoster—Experimental Physiology.

**BOOKS AND PAMPHLETS RECEIVED.**—The Ship Captain's Medical Guide. Compiled by Harry Leach, Resident Medical officer Hospital-ship "Dreadnought." Second Edition. London: Simpkin, Marshall & Co.—Second Annual Report of the Board of Trustees and Officers of the Minnesota Hospital for the Insane, for the year 1868.—Annual Report of the New England Hospital for Women and Children, for the year ending Nov. 1, 1868.

**MARRIED.**—At Chelsea, Feb. 3d, Dr. Geo. W. Churchill to Miss Lydia A. Shaw.

**DIED.**—At Cambridge, Feb. 4th, John Appleton, M.D., aged 60.

**DEATHS IN BOSTON** for the week ending Saturday noon, February 13th. 104. Males, 50—Females, 54.—Accident, 3—apoplexy, 1—inflammations of the bowels, 3—congestion of the brain, 1—disease of the brain, 4—bronchitis, 3—cancer, 1—consumption, 11—convulsions, 2—croup, 1—cyanosis, 2—debility, 2—diarrhea, 1—diphtheria, 2—dropsy, 3—dropsy of the brain, 4—erysipelas, 3—scarlet fever, 12—typhoid fever, 2—disease of the heart, 2—intemperance, 1—disease of the kidneys, 2—congestion of the lungs, 2—inflammation of the lungs, 9—marasmus, 4—measles, 3—cerebro-spinal meningitis, 1—old age, 1—paralysis, 2—peritonitis, 2—pleurisy, 1—premature birth, 2—puerperal disease, 3—purpura, 1—scalded, 2—score throat, 2—unknown, 3.

Under 5 years of age, 51—between 5 and 20 years, 10—between 20 and 40 years, 23—between 40 and 60 years, 8—above 60 years, 12. Born in the United States, 32—Ireland, 20—other places, 2.